

Why Eradicate?

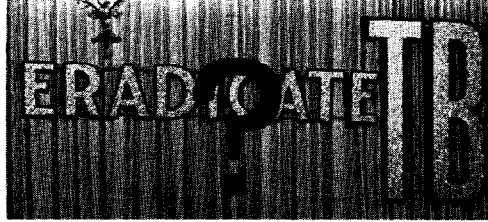
June
1962



CRUSADER

OF THE WISCONSIN ANTI-TUBERCULOSIS ASSOCIATION

All photos except pp 5 and 15 (lower)
by James Bruffat.



A Concept

TODAY a new and inspiring goal beckons to tuberculosis and public health workers. Much has been done in the past, with our sights set upon *control* of tuberculosis. But all that has been done before is but the prelude to the job ahead — its *eradication*.

That goal is eminently feasible. The tools we now have are, in the main, basically adequate. Some new ones will have to be devised. What is needed most is conviction that tuberculosis *can* be eradicated, and the will to do the job.

The specific goals we must work for will differ from those in the past.

Their form cannot be spelled precisely and in all details. But:

- We must improve and expand our methods of case detection in order that new cases may be picked up before their disease has been implanted in others;
- We must do a better job than we have ever done before in finding the source of infection among young children and others who react positively to the tuberculin skin test;
- We must aggressively seek supervision and treatment of every known active case until there is no danger of infection of other persons;
- We must use isoniazid effectively and promptly to prevent open, tuberculous disease among young children who are positive reactors to tuberculin and among older children and adults who have recently converted from a negative to a positive skin test.
- We must recognize that in seeking eradication, our greatest difficulties lie ahead. They will come into view as the eradication campaign gains experience. But so too should their solutions.

In short, we have one immediate, intermediate and final goal for our TB eradication program: to block all transmission of infection from one individ-

“AYE!”

A Resolution

ual to another. This must be our constant objective, even though we must begin with specific population groups or geographic areas.

To achieve this end, we have some machinery, including health departments, sanatoriums and voluntary tuberculosis associations. But these are not enough. The program for eradication of tuberculosis must have the enthusiastic support of physicians, both as individuals and as members of organizations; other health and welfare agencies, to share in cooperative activities; schools, press and airwaves, to inform the public; informed volunteers to educate, promote and demonstrate. Legislators must be encouraged to support “all-out” eradication programs now in order that “control” programs will not have to be financed indefinitely.

TO ALL of these groups there must be a new dedication: to put away any sense of complacency over past achievements. Whenever groups of people are exposed to tuberculosis because case-finding programs have lagged, whenever children react positively to tuberculin, whenever advanced cases are discovered, we must ask ourselves, “Why have we failed? How can we prevent it happening again?”

Already we have small areas where the chain of infection has been broken, where no children react to the tuberculin skin test. These “cradicated” areas demonstrate that prevention of infection *is* an attainable goal. From these small areas of already achieved victory a widening program of eradication must spread until we are able to say, “Tuberculosis *is* conquered.”

BE IT RESOLVED, that the Wisconsin Anti-Tuberculosis Association invite its professional and lay co-workers, both in agencies and as individuals, to join in seeking the goal of eradication of tuberculosis and not merely its control; and

BE IT FURTHER RESOLVED, that there be explored and developed during the coming year specific ways and means by which the objective of eradication may be most rapidly achieved.

Adopted at the WATA Annual Membership Meeting, April 12, 1962. Material on the following pages is abstracted from the 1962 Annual Meeting eradication sessions.

ERADICATION

"To Pluck Up By The Roots"

From the Keynote address

by FRED L. SOPER, M.D., DR. P.H.

WHEN asked to name my specialty in the field of medicine, I describe myself as a public health administrator. But in the American Public Health Association, I belong to the Epidemiology Section. I have never worked in tuberculosis; I see your problem as one of public health administration in communicable disease prevention.

I greatly appreciate the opportunity this spring to speak to several of the state tuberculosis association meetings. I am getting a vision of the mechanism through which eventually the eradication of tuberculosis must come in the United States.

My title today, "Why Eradicate Tuberculosis?" implies a choice; that we can eradicate this disease or, by choice, leave the seed of infection as a permanent curse on the race. My answer to the question, "Why Eradicate Tuberculosis?" I give you now, so we can talk about other things. It's a very simple answer . . . WE SHOULD ERADICATE TUBERCULOSIS BECAUSE IT IS POSSIBLE TO DO SO!

This is answer enough for those who know and remember what tuberculosis has meant and still means to the human race. We must eradicate tuberculosis because we cannot, in good conscience, leave it as a heritage to future generations.

ERADICATION requires conviction, dedication, even fanaticism, which cannot be generated without faith in the objective. When I talk about eradication, I speak in terms of the absolute.

In eradication, one has an advantage in measuring success always against absolute zero. Any infection is too many.

Tuberculosis workers may well find that the lower levels of disease incidence require techniques of finding infection and of eliminating transmission quite different from those previously used so successfully when tuberculosis was relatively common.

As a special consultant for the division of international health in the USPHS department of health, education and welfare, Dr. Soper has dedicated himself to the eradication of communicable diseases. He has challenged TB workers to apply his concept to the fight against the disease.



A principle now emerging in international health (certainly at some future date applicable to tuberculosis) is that countries which free themselves of a disease or a disease vector are entitled to protection against reinfection and reinfestation by measures to be taken by their neighbors.

To be feasible, eradication must cover an appreciable area and be ready to expand. If you want eradication in Wisconsin, you must have it in Illinois, you must have it in Minnesota, and eventually in an ever expanding periphery. Obviously, once you embark on disease eradication, you acquire an interest and stake in the welfare of the entire human race.

THERE is no Law of Diminishing Returns and no indestructibility of a biological entity. The mathematics of eradication is simple; what can be done in one square meter can be done in two square meters; what can be done in two square meters can be done in four. Thus, by geometrical progression the world is soon covered.

It must be remembered that eradication is based on complete coverage of the population and of the area concerned. So-called underdeveloped countries need not be behind the so-called developed countries in carrying out certain specific eradication programs.

Both smallpox and malaria are being attacked with determination to bring about biological eradication. I believe the same can and should be done for tuberculosis.

Localized epidemics are the mechanism through which tuberculosis, as a dangerous, contagious and infectious disease will be able to maintain itself if it is not eradicated.

(Continued on next page)



**"We should
eradicate TB
because it is
possible to
do so . . ."**

Experience with other eradication projects suggests that there are many and various problems to be solved in the eradication of such a widespread chronic infection as is tuberculosis. These problems are psychological, technical, administrative, educational and financial in nature.

The solution of entire groups of these problems, however, may depend on decisions on a few basic points. Among them I would put the following:

1. Definition of eradication as an absolute; acceptance by the national and state health authorities and by interested voluntary agencies of eradication of tuberculosis, as thus defined, as a feasible and urgent objective.
2. The acceptance of tuberculosis as no longer essentially a social and economic, but rather a public health and medical administrative problem; establishing the responsibility of the community to the infected individual; but also establishing the responsibility of the infected individual to uninfected persons.

There is an important lesson for tuberculosis workers in the experience with the eradication of bovine tuberculosis in the United States.

The bovine tuberculosis eradication program began in 1917. In the beginning, this program was based on the certification of individual herds as free of tuberculosis, that is, having no tuberculin test positives.

After a number of years, the program was changed and certification was by counties and was based on the finding of a very low, below half of one percent, positive tuberculin rate. As early as 1940, all of the counties of the United States were certified on this basis.

The campaign has continued; the incidence of bovine tuberculosis declined until about 1954. But since 1954, it has begun to rise again.

The lesson is: *there is no place to stop short of eradication!*

**"We are going
to eradicate
TB because of
the tragedy of
not doing it."**



A WORD on the cost of eradication. The cost is going to be high. It cannot be accomplished by tapering off on expenditures nor by reducing effort. If costs are figured on the basis of cases found, and retreat is ordered as the cost per case goes up, eradication is doomed to defeat.

Per capita costs should be calculated on the basis of the population protected against infection rather than on the number of infected persons found and treated.

And the initial cost of eradication in a local community is not the end. To get the benefits of eradication for ourselves we must help our neighbors to eradicate. This we must do gladly and willingly, because only so can we protect ourselves.

It makes no difference what eradication costs! It makes no difference what effort is needed. The stake is so enormous, it will be worth it.

Eradication as an objective is salable; salable for itself for new health dollars not in competition with other health programs for dollars already earmarked for health. Let us have the courage to advocate eradication of tuberculosis, for which no effort is too great, no price too high.

**WE ARE GOING TO ERADICATE TUBERCULOSIS BECAUSE OF
THE TRAGEDY OF NOT DOING IT.**

You, along with other similar groups, have the possibility and the responsibility of starting this program of world eradication of tuberculosis.

Dr. Fred L. Soper's paper, "Problems to be Solved if the Eradication of Tuberculosis is to be Realized," presented at the 1961 annual meeting of the American Public Health Association, was published in the June, 1962, issue of the National Tuberculosis Association Bulletin. Free reprints may be obtained on request to the WATA.

ERADICATE TB



Mr. Duckworth, Dr. Edwards, Dr. Anderson

Is It Feasible?

A Panel Discussion



Dr. Soper, Dr. Stead, Dr. Wilkie

T. A. DUCKWORTH

Senior vice-president and secretary, Employers Mutuals of Wausau

Medical science tells us that this goal can be accomplished, that we can eradicate TB. But will we? That is the next question. What people *can* do and what we *will* do are entirely different.

I think we have to recognize that we live in a world of emotion and not in a world of reason. And we have to appeal to the emotions of the citizenry as well as to the reason.

I think eradication is a tremendous idea and I think it's going to live on. Men live for ideas and most of us underestimate the power of ideas. Men come and go and ideas live on forever.

We do not yet have an informed public which understands the concept of eradication and at the moment, therefore, is not in a position to oppose, support or otherwise have an opinion.

It will be necessary to receive the support of the public, the communities, the region, the states and the nation as a whole for the bigger effort which will be required for eradication to be launched and continued to the end. The public will need to know that tuberculosis continues to be a dangerous disease and that any incidence is too much where the means of blotting out the disorder are at hand.

I was impressed with Dr. Soper saying zero is our goal. I think Americans and the world at large have to work toward goals.

I was impressed with the fact that he mentioned the word *faith*.

If the world at large has the faith and accepts zero as the goal there is no doubt that at once we can work toward eradication.

A. C. EDWARDS, M.D., M.P.H.

Commissioner of Health, Racine

The acceptance of eradication is an interesting challenge.

Dr. Soper impressed me with the idea that tuberculosis is no longer a

social and economic problem, but rather a public health and medical administration problem.

I think the Wisconsin Anti-Tuberculosis Association for many years has fostered the idea that tuberculosis was a social problem with a medical aspect. It seems to me I've heard that many times at these sessions, and I'm glad to see that Dr. Soper feels the time has come when we have to forget about the social aspects and look at it as a problem of administration.

As he says, if we can eliminate tuberculosis in cattle handled in Minnesota, it ought to be possible to eliminate tuberculosis in human beings in Wisconsin.

WILLIAM STEAD, M.D.

Associate professor of medicine, Marquette University School of Medicine; clinical director, Muirdale Sanatorium

I think that there is a great deal of merit to Dr. Soper's approach. We must not be satisfied with reducing tuberculosis infection to a "reasonable level" and then cutting the budget and the effort. We must go further than that if we are to achieve eradication.

As the number of tuberculin positive people drops, should we not begin to think of changing to a careful follow-up of only those who are positive as our primary control effort rather than using chest x-rays of the entire population as our principal tool? We must look for the TB germ in its places of hiding so that we may search it out and prevent its spread.

Detection of disease before it becomes contagious and before it is transmitted to children is *true* primary prevention. A completely effective program of this kind would yield wonderful results in one generation, but would require an increase in the effort of all of us.

Eradication is more than just "more control." Among other things we shall have to reassess many of our present ideas and methods. Further information

(Continued on page 13)

To Achieve O Absolute

A panel discussion of practical
means to achieve eradication

R. P. JAHN, M.D.

WATA medical director, Milwaukee

There is a tremendous job ahead—a job of eradication which will occupy all of our time for a long time to come. Eradication is the creed whose adoption is really worth working for.

There are some things we emphatically should not do. One of them is to desert prematurely certain tried, true and effective measures and procedures. There is great danger in becoming too visionary and saying everything is going to be new and everything is going to have to be done differently.

I do not maintain that we should continue to do everything as we are. We must add, we must supplement, we must go along further. But let us not abandon those things which are working today.

RAYMOND EVERS, M.D.

Superintendent and medical director, Rocky Knoll Sanatorium and Hospital, Plymouth

I feel very strongly that if we use the tools we have available now in the way they should be used we can eradicate tuberculosis in the not distant future.

We can accomplish this purpose by two very easy methods that we are using already. First, we can do more tuberculin testing.

I would like to see a law passed making it compulsory for every person to have a tuberculin test. I would like to see a record kept in the county nurse's office and the city nurse's office. I would like to have a city-county department, of course, with all the records in the same place and with a record of every person in the county who has a positive tuberculin test.

Second, the prophylaxis of tuberculosis is probably the most exciting procedure that we have available at the present time.

All of us who work in tuberculosis should make more use of isoniazid. We should take people who have been patients in the past and have never had isoniazid therapy and start them on prophylactic treatment.



L. to R. Dr. Evers, Miss Payer, Mr. Lifson, Dr. Jahn, Dr. Feig.

Probably in the near future we will be treating with isoniazid any person who has a positive tuberculin test. I may be wrong but this method in the long run may be very effective.

JEANETTE PAYER, R.N.

Supervisory nurse, West Allis Health Department

No matter what the concept might be, public health nursing will not make a dramatic change.

We have a job to do before we begin. We have to go home and tell our cohorts what we have learned. This is our first way of spreading the good word. For this program to be effective, we must spread the word and we must spread it to everybody, not just to a few people who are in health work.

We are all concerned about the patient. But what about the contacts? Do we give the contacts nearly the amount of consideration and treatment we do the patient?

That is very important. It is another stepping stone toward eradication. Catch them early before they are communicable.

If the public is apathetic, it is our fault. As public health nurses, we have contact with the public and I think we have to stir people up a bit. It certainly can help to educate the public in eradication rather than control. Can we talk it up enough?

MILTON FEIG, M.D., M.P.H.

Director, section on preventable diseases, State Board of Health, Madison

If we are to achieve further marked progress in tuberculosis control, we must know where we now stand. We must also look back, we must try to reason how we got to our present situation.

(Continued on next page)

Absolute Zero, cont. from page 11

We must make up our minds also where we want to go and most important of all when we wish to arrive at this goal regardless of what the goal is.

THE methods that have been used before may no longer be satisfactory or they may have to be modified somewhat or improved. Or perhaps new methods might become available to us.

I think it is very important not to set eradication before the public as an end point. We should seize on an intermediate objective in the community.

I suggest that we try to cut down the case rate of 20 per 100,000 persons to 10.

I propose that we set a time limit for five years, and if we have achieved this goal, we can then go on to the final end point.

SOL LIFSON, M.P.H.

Director, Education and Public Relations, National Tuberculosis Association

The challenge before us is to put what we currently know about treatment to work to rid our country of this age-old disease.

We must convince our legislatures that it makes good fiscal sense to invest large sums of money now for eradication programs, since it will mean that the bill to the community in years to come will be infinitesimal compared to what it now costs.

As I see it, the voluntary tuberculosis associations must take the lead in promoting the concept of eradication. Each member of a board of directors must convince himself that eradication is possible. He must also be willing to work assiduously for the achievement of this goal.

When we have convinced ourselves and other responsible leadership groups, the really big job is before us. We must educate each person in our communities to the idea that he has a responsibility and obligation to know what his tuberculosis status is and to take action in accordance with that status.

There must also be an educational program directed at the physicians of the community.

Nurses, social workers and all other professional workers related to health must become partners in the all-out eradication program. Industry should play a primary role. Schools and colleges need to devote time to teaching the facts about tuberculosis and to looking for active cases through tuberculin-testing programs.

When we reach the stage where having tuberculosis is socially unacceptable, we will probably be close to the eradication of this unnecessary disease.

Is It Feasible?, cont. from page 9

mation on the *natural history* of tuberculosis will be needed to guide us in achieving the goal of eradication.

JAMES M. WILKIE, M.D.

Medical director, Morningside Sanatorium, Madison

The goal of eradication is a proper one. We have reason to believe that we can approximate such a goal.

It means we are going to have to change our methods and our ideas about how to approach tuberculosis. Much of our old thinking is going to have to be thrown away.

In the field of cost alone, we are not necessarily going to think of doing that type of examination where we will find the most new cases of tuberculosis for the least cost. We are going to reach the point where each new case is going to cost us a lot of money.

And we are not always going to look for tuberculosis in the place where it is most apt to be found. We are going to have to look for tuberculosis in the places where it is least apt to be found.

This is going to take time and tremendous effort.

We are going to have to make up our minds to the fact that there will be a mass of tubercle bacilli in living people and that these people will carry those seeds of potential infection in their systems for the rest of their lives.

Those people will all have to be watched to be sure that those germs do not break loose and become a danger to the public.

At the same time we will have a younger generation growing up.

And it is here where eradication possibly reaches its climax. By carefully examining all the younger people who are uninfected and doing everything that we can to prevent them from becoming infected, we may eventually reach a point where we will have generations coming on who have not had the experience of any tuberculosis.

This I think is the goal that we should shoot for.

F. L. SOPER, M.D., Dr. P.H.

We must change our point of attack. We must change our point of focus.

One of the very simple and one of the easiest things to do is to stop talking about rates. Stop talking about so many deaths per 100,000 or so many cases per 100,000.

Let's try to individualize the cases. Let's try to make people out of these cases and say that so many persons have tuberculosis or so many individuals.

We have to build up the public acceptance, and we can build up the public acceptance only as this group becomes convinced that eradication is possible and that it is worthwhile.

John Lindner, Sr. Receives DS Award

THE president of the board of trustees of Mount Washington Sanatorium received the WATA's 1962 distinguished service award at the annual meeting luncheon, April 13.

The citation describes John Lindner, Sr., as "the immigrant boy . . . who found in America the opportunity to achieve material success . . . and the opportunity to serve his fellow-men."

The Eau Claire businessman's first job in the United States was as a fireman in a Chicago hospital. He later moved to northern Wisconsin to farm, then became a sales representative for road machinery companies. He rose to the presidency of one of those firms.

In the words of the citation: "Material success did not limit his life."

In 1928, Mr. Lindner was elected a trustee of Mount Washington. Under his leadership as board president, the sanatorium was one of the first to convert to a dual-purpose operation . . . caring for tuberculosis patients and serving as a home for the aged.

Mr. Lindner is a charter member and past president of the Wisconsin Sanatorium Trustees Association and has appeared frequently before legislative hearings. He speaks "plainly, almost gruffly, but with a salty and disarming humor" in backing legislation to aid sanatoriums and their patients.

As the citation puts it. . . . "He has, in fact, been an unforgettable personality."



The Rev. Walter Piehler (right), retiring WATA president, presents the WATA 1962 Distinguished Service Award to Mr. Lindner, Sr.

The CRUSADER

of the

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You'll be interested to know that . . .

- Former WATA Publications Director Harold Holand has been named to the new position of assistant to the executive secretary. The author of the WATA history, "House of Open Doors" became director of the research and publications department in 1943.

Named to succeed Mr. Holand is Gordon Krenn, a graduate of the University of Wisconsin. Mr. Krenn has worked as a reporter for radio station WIBA and the Capital Times in Madison and for WTMJ—WTMJ-TV News in Milwaukee.



G. Krenn

- George C. Owen, M.D., Milwaukee, was named president-elect of the WATA at the annual business meeting, April 12. Dr. Owen succeeds M. S. Dailey, Oshkosh, who took over as president.

Harry G. Marsh, Madison, was elected vice-president. Elwood P. Mason, M.D., and James P. Fitch, Milwaukee, were re-elected as secretary and treasurer.

Named to the board to replace retiring Mrs. Marie Hoyer, Oshkosh, was Arthur W. Bouffard of Green Bay, district supervisor, state rehabilitation division.

- Richard P. Jahn, M.D., WATA medical director, was named president of the Wisconsin Thoracic Society at its business meeting, April 14. Others elected were Ben R. Lawton, M.D., Marshfield, vice-president; William Stead, M.D., Milwaukee, secretary; and J. Richard Johnson, M.D., Madison, treasurer.

- Below, Elizabeth L. Ryan, director, WATA health education-local association department, receives an award from James E. Perkins, M.D., managing director, National Tuberculosis Association, for her work as a professional staff state TB association member.



THE WATA IS GUIDED BY THESE

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M. S. Dailey*	President
George C. Owen, M.D.*	President-elect
Harry G. Marsh*	Second Vice President
Elwood W. Mason, M.D.*	Secretary
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*Ex-Officio Members of Executive Committee
**Members of Executive Committee

Attention Nurses

A series of one-day tuberculosis nursing institutes is planned for this fall as a "review and up-dating" regarding the nature and treatment of TB.

Institute Director:

Miss Ruth Leininger, R.N., assistant director,
Nursing Advisory Service of the
National Tuberculosis Association — National League for Nurses.

Co-sponsored by:

University of Wisconsin, Madison
Wisconsin Interorganization Committee on
Tuberculosis Nursing

Plan now to attend at one of the following locations:

La Crosse, September 11

Rice Lake, September 12

Green Bay, September 14

For more information write: Case-Finding Department, WATA
Box 424, Milwaukee 1, Wisconsin

The CRUSADER

Milwaukee 1, Wis.

of the Wisconsin Anti-Tuberculosis Ass'n

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